REPORT ON STATE HOSPITALS FOR MENTAL DISEASES

COMMITTEE ON HEALTH

IOWA STATE PLANNING BOARD

JANUARY 1939

REPORT
ON
STATE HOSPITALS FOR MENTAL DISEASES

Committee on Health
IOWA STATE PLANNING BOARD
January 1939

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LETTER OF TRANSMITTAL

* * * * *

January 25, 1939

The Honorable George A. Wilson
Governor of Iowa
State House
Des Moines, Iowa

Dear Sir:

The State Planning Board transmits herewith a report, from its Health Committee, on the state mental hospitals.

A large number of public spirited citizens have cooperated in making the studies of conditions and problems covered in this report. The State Planning Board hopes that the committee report will be helpful in the consideration of needed improvements.

Respectfully submitted,

H. H. Kildee, Chairman,
IOWA STATE PLANNING BOARD

HHK:H

LETTER OF TRANSMITTAL

Dean H. H. Kildee, Chairman
Iowa State Planning Board

Dear Sir:

It is my pleasure to transmit herewith the report of the Committee on Health on the State Hospitals for Mental Diseases.

The information contained in this report was made available as the result of visits to the different state hospitals by subcommittees appointed for that purpose, by frequent reference to the report of the Mental Hospital Survey Committee, and that of the State Board of Control, as well as extended correspondence with related institutions and authorities in other states.

The results of these studies have been further summarized in the reports submitted by the respective chairmen of the subcommittees on Professional Staff and Hospital Equipment.

In their generous devotion of time to the work leading to this report the members of the Committee have contributed freely of their expert knowledge and rendered a high degree of public service which is deserving of the fullest recognition.

It is hoped that the factual data here presented will be of service to the Governor and members of the 48th General Assembly in determining the necessary legislative action towards improving existing conditions in the state hospitals for mental diseases.

Respectfully submitted,

Walter L. Bierring, M.D.,
Chairman
Committee on Health

January 23, 1939

REPORT OF THE CHAIRMAN

OF THE SUB-COMMITTEE ON PROFESSIONAL STAFF

APPOINTED BY THE

COMMITTEE ON HEALTH OF THE IOWA STATE PLANNING BOARD

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November 18, 1938.

Walter L. Bierring, M.D., Chairman,
Committee on Health
Iowa State Planning Board
Des Moines, Iowa.

Dear Doctor Bierring:

Pursuant to your request allow me to summarize the recommendations of the Sub-committee on Professional Staff, and to comment upon certain items contained in this report.

Respectfully submitted,

Andrew H. Woods, M.D.,
Chairman of Sub-committee
on Professional Personnel

REPORT OF THE CHAIRMAN

OF THE SUB-COMMITTEE ON PROFESSIONAL STAFF

APPOINTED BY THE

COMMITTEE ON HEALTH OF THE IOWA STATE PLANNING BOARD

1. It was the opinion of the sub-committee that the service rendered to the state by the state hospitals for the insane and the institutions for the mentally defective and epileptic is unsatisfactory and that this condition is due primarily to inadequacies in the professional staff.

2. The sub-committee approved of the recommendations of the Board of Control as to the numbers of professional personnel under each of the various classifications as set forth on page 4 of their "Report and Recommendations covering a ten year Improvement Program, etc." which was prepared at the request of the Committee on Retrenchment and Reform and published as of April, 1938. Their report revealed correct insight as to the essential needs of their institutions and as to the relatively greater importance of the professional staffs, while, nevertheless, laying due emphasis upon the importance of bringing the physical equipment up from its present inadequacy to a level consonant with safety and with the efficient functioning of the proposed enlarged staff.

3. The total financial outlay per annum involved in maintaining such a professional staff will vary according to the amount of training and experience desired by the state in the persons employed. Guided by the experience of the better hospitals for the insane in other states, the sub-committee has made the following estimates as to a reasonable annual appropriation for the professional staff listed below.

If it will be satisfactory to keep out of the competitive market and accept personnel not sought by other hospitals, the salary scale given below can be reduced as much as 25%.

STATE HOSPITALS FOR THE INSANE

	For one hospital of 1,500 beds	For a total of 7,500 patients
1 Medical superintendent		
1 Clinical director		
1 Pathologist		
8 Other physicians and interns		
Total for physicians	$ 35,800	$ 179,000
1 Superintendent of nurses		
2 Supervisors of nurses		
34 Other registered nurses		
150 Attendants		
Total for nursing	135,500	677,500
1 Dentist		
1 Pharmacist		
3 Technicians		
3 Social Workers		
3 Occupational therapists		
3 Physiotherapists		
1 Recreation Director		
1 Psychometrist		
Total for other staff members	20,500	102,500
	$ 191,800	$959,000

The cost for salaries per patient for the professional personnel listed above will be $128 per year, or 35¢ a day.

Salaries and wages for all kinds of employes in the state hospitals of Iowa today amount to 17½¢ per patient; in Massachusetts, 52¢.

INSTITUTIONS FOR THE MENTALLY DEFECTIVE AND EPILEPTIC

(a) Since epileptic patients, that are not mentally defective, call for entirely different treatment and training from the kinds applicable to mentally defective patients, the advisability should be considered of providing a special hospital for the treatment of epilepsy.

(b) It is to be taken into account also, in preparing physical plants and professional staffs for the two institutions now responsible for the mentally defective, that by proper classification and treatment it will probably be possible that return home or other more satisfactory disposition will become possible for many of these patients, thereby reducing the population of the institutions.

(c) In considering the treatment appropriate for mentally defective patients, experience shows that from the borderline down to higher moron intelligence levels only rudimentary school work is productive of good; below the mid-moron level, it should be progressively reduced.

These patients are often possessed of good feelings and character, so that for the higher morons social adjustment may be developed and self support outside of institutions is the objective of training. They become confused in school work that is purely memoriter and above their grasp. Emphasis is to be laid upon practical work, guidance in recreation and social training.

The next lower grades of inmates will remain within the institutions for life, but after training they become useful workers within the institutions. Formal schooling is useless for them. Those at the lowest intellectual levels require only custodial care.

In the following list of professional workers recommended by the chairman of the sub-committee for these two institutions, it will be noted that fewer physicians are needed than are called for in the care of the insane patients. The relative numbers of craft workers, vocational instructors and school teachers suggested may be varied at the discretion of the superintendents, according to the proportions of patients of lower and higher intelligence. The number of registered nurses will be determined by the actual needs of infirmary patients.

The reports of these two institutions, as given in the statistics for 1937, reveal that the average daily attendance was as follows:

Feebleminded	2,795
Epileptic	469
Total	3,264

The professional staff recommended for this number of feebleminded persons is as follows (for two institutions):

2 Medical superintendents, 2 pathologists, 6 assistant physicians, 4 interns	$ 41,200
2 Dentists	5,000
4 Social workers and 4 psychometrists	10,000
2 Directors of craft work, 4 first assistant craft workers, 12 second assistant craft workers	20,400
2 Directors of vocational work with 8 assistants. Also all heads of maintenance departments should be capable of giving vocational training	13,200
2 Directors of recreation, 2 assistants and 2 second assistants	6,200
2 Superintendents of nursing and 8 assistant nurses, 14 nursing attendents	21,640

Trained caretakers: 2 superintedents, 6 assistant superintendents, 200 trained attendents	$152,000
School teachers: 2 superintendents and 40 teachers	51,400
4 Directors of music	6,400
Total salaries for the above professional staff per annum - - - -	$327,440

Average per patient per year for professional staff, $117, a slightly lower average cost per patient than is necessary for the care of insane persons.

The trained caretakers will have detailed responsibility for the inmates and will be responsible for each group being present on time at the various assignments to the schools, craft shops, gardens, playgrounds, infirmaries, and for the care of each group when not thus delivered to the supervision of others. These attendants would be in charge of the patients at meal hours, in the dormitories and on all occasions when other definite assignments were not made in the daily program.

HOSPITAL FOR EPILEPTIC PATIENTS

For 500 epileptic patients an allowance of $64,000 is recommended to provide the professional personnel needed.

5. Staff development for the hospitals and other institutions will be gradual. The number of physicians and nurses available in America for junior positions in the hospitals for the insane and in institutions for the feebleminded and epileptic is sufficient to supply the needs outlined above. The scarcity of physicians, superintendents of nurses and psychiatrically trained nurses, experienced in caring for mental patients, will determine, however, that at least five years will be required for carrying out the whole proposed program. The key positions in each institution under the medical superintendent are those of the clinical director, senior

assistant psychiatrists and trained nurses capable of organizing nursing work and training attendants. An effort hurriedly to bring together complete medical and nursing staffs will result in confusion and inefficiency.

If the people of the state would be content to permit the development of one hospital and one of the institutions for the feebleminded at a time, the final organization of the work throughout the state would be better assured.

If that procedure is not feasible, it is recommended that for the first year the most important positions in each of the institutions be filled by persons whose advice and assistance will be valued by the medical superintendents in selecting and training those who will later be called to the remaining positions. It is proposed that the first staff members to be added to the present staff shall be:

For each state hospital for the insane: One clinical director, one assistant and two junior physicians, one superintendent and two supervisors of nursing, ten registered nurses and fifty attendants.

For each institution for the feebleminded: Three physicians, one director of craft work, one director of vocational work, one director of recreation, the head caretaker and one assistant, fifty caretaking attendants, the superintendent of nursing, three assistant nurses and five nursing attendants.

For epileptic patients, a clinical director, three assistant physicians, one superintendent of nursing, ten registered nurses and forty attendants.

6. Relationship of the State Psychopathic Hospital. During the past ten years the State Psychopathic Hospital has sought to make its facilities available to assist the superintendents of the state hospitals for the insane and the institutions for the feebleminded and epileptic in a number of specific ways.

(a) It has invited the superintendents to send assistant physicians to the Psychopathic Hospital for periods of a month or more at a time for courses in psychiatry and for the working out of research problems connected with their hospital work.

(b) It has attempted to find desirable assistant physicians for the state hospitals from assistants trained by it and from outside. Three physicians trained in the Psychopathic Hospital have accepted state hospital positions. In most instances, however, various considerations led available ex-interns and ex-resident physicians to accept other positions.

(c) The Psychopathic Hospital maintains a neuropathological laboratory with an experienced pathologist and two technicians, the chief purpose of which is to prepare, study and make reports upon the brains and other nervous tissues of patients who had died in the state hospitals.

(d) It has carried on a post-graduate nursing course in psychiatric nursing, the main object of which was to supply trained psychiatric nurses for the state institutions.

(e) It offered to accept and train occupational therapists and social workers for use in their hospitals.

The superintendents of the state hospitals and other institutions expressed appreciation of these opportunities, but were hindered in utilizing them for the benefit of their staffs largely because of the impossibility of releasing staff members for courses in psychiatry. It was further impossible for the superintendents to avail themselves of the psychiatrically trained nurses, because of the lack of state appropriations for the payment of nurses' salaries.

Since the State Psychopathic Hospital is primarily a center for the teaching of psychiatry and for intensive therapeutic effort upon selected patients, the College of Medicine of the State University has encouraged the director in every effort to make the institution helpful to the work that is carried on under the Board of Control of State Institutions.

In view of the present effort of the Board of Control and the superintendents of the medical institutions to secure adequate professional assistants, the director and staff of the Psychopathic Hospital more

heartily than ever desire to cooperate with them in attaining that present purpose and in the furtherance of the work for mentally disordered patients in coming years.

7. The coordination of various agencies in the state of Iowa concerned with mental disorders. In view of the importance of the considerable number of diverse efforts that are being made throughout the state for the care and relief of mental disorders, the sub-committee on professional personnel commends for consideration the desirability of establishing by law an administrative organization qualified by reason of experience in psychiatry to bring into harmonious and efficient cooperation the following activities:

The state hospitals for mental diseases
The institutions for the mentally defective and epileptic
The operations of the commissions of insanity and the rectification of undesirable features in the present procedures for commitment
The care of insane criminals
Examinations and recommendations to courts of law concerning those charged with crime
The Eugenics Board and the sterilization of the unfit
The care of alcoholic and drug addicts in appropriate institutions
The establishment and maintenance of mental health centers
Institutional and other provisions for the training of boys and girls who show serious misbehavior and potential criminality

In this connection attention is called to certain points:

(a) The experience, outlined below, of certain other states and the kinds of organizations that have been established in them by law are instructive. (See Appendix, pp. 12-16)

(b) The advantages and dangers of centralized control of scientific work.

1. Some have feared that a unifying agency would stifle individual initiative, burden the separate institutions with regulations and magnify official formalities.

2. The questions of the cost to the state of maintaining a department of the government for this purpose and the value of the resulting benefit will have to be considered.

3. Frederick W. Parsons, M.D., recently retired Commissioner of Mental Hygiene of New York State, says, in this connection, "A state which supports eighty thousand inmates in twenty-six institutions, all having a common interest, in order to attain a degree of harmony, necessarily must have standards. If there were no central office, and if those in control of twenty-six different institutions pursued their own individual policies, the resulting chaos could be more severely criticized than the order which follows what has been called 'regimentation'. Departmental control need not be bureaucratic. It can be a spur to the laggard and a curb to the over-enthusiastic, and within those limits there is scope for personal expression."

(c) More humane protection vs scientific treatment of insane persons. In some states emphasis regarding mental disorders is placed upon the protection of life, property and the peace of the communities, but always with the proper protection of the patients themselves and their rights as an important desideratum. In those states the operations of hospitals and other institutions are controlled by men of ability and experience in accounting and general administration.

In Virginia, for instance, the Governor of the State appoints, for a term of four years, the Commissioner of State Hospitals for the Insane, who must be a skilled accountant. He is ex officio the chairman of the General Board of Directors of state institutions for mental disorders and of each Special Board of Directors for the individual hospitals. The General Board appoints the medical superintendents of the hospitals and supervises the operations of the Special Boards. Each Special Board has immediate supervision of one individual hospital. The superintendents have full medical charge of their own institutions. The Boards are concerned largely with business administration and general policies.

In some states the study of mental disorders, search for causes and efforts at cure are emphasized, while due consideration is given to the comfort and security of the patients and of the whole social group, which might be disturbed by them, and to general financial and administrative procedures. The organization of the state's efforts to attain these objectives is administered by physicians selected because of experience and ability in the scientific field of mental disease and because of administrative capacity in coordinating available resources, providing suitable physical plants and apparatus, and in the economical use of financial appropriations.

APPENDIX

GOVERNMENTAL DEPARTMENTS

IN VARIOUS STATES

SUPERVISING CARE OF MENTAL DISORDERS

In Maryland the Board of Mental Hygiene was at first established as a supervisory body, which was required to investigate and report to the state authorities as to the safekeeping of patients and the efficiency of all public and private institutions that dealt with mental disorders. No actual control was given to this Board regarding hospital finance and the selection of personnel. All appointments, however, have been well protected by a strong civil service department which has vigorous public backing.

This organization has evolved a form of control marked by considerable efficiency and success, partly because of the elasticity of the law, but largely because of the fortunate selection of the present Commissioner of Mental Hygiene. Recognized as an able psychiatrist and trusted for personal integrity, he gained confidence among the separate Hospital Boards that controlled the individual institutions and among the superintendents and physicians of each hospital. The present successful administration through the Board of Mental Hygiene grew out of early informal conferences of the Commissioner with the various officers. At present, without any coercive authority, the Commissioner has gained a working relationship, which leads the Hospital Boards and the superintendents to discuss with him their requests for appropriations, plans for changes in personnel and equipment, salary scales and the general policies of each institution. Complaints are sent from patients or other individuals or agencies throughout the state directly to the Board of Mental Hygiene. These complaints are discussed by the Commissioner with the officers concerned and appropriate action follows.

The result of this relationship has been that all the mental health agencies of the state of Maryland have risen to higher and higher efficiency during the passing years, because of the uniform and harmonious cooperation both as to scientific methods and administrative procedures that has spontaneously evolved. For instance, although there is no legal requirement for it, the public and private hospitals for mental diseases in the state report daily by telephone to the Board of Mental Hygiene all patients admitted or discharged. In this way, the most economical shifts of patients are arranged and information regarding patients is shared among all the institutions. At present the Board of Mental Hygiene maintains a complete hospital record of every patient who has been in any mental hospital in the state. Through this voluntary arrangement, all applications from the counties for admissions are handled in the office of the Board and the assignment to a particular hospital is arranged by telephonic communication with the hospital.

The good psychiatric judgment of the Commissioner in consultation with the superintendents enables him to arrange for the discharge or other methods of care of certain patients, so that beds can be freed for more pressing cases without working hardship on those discharged. This central control has resulted in the diminution of overcrowding in the institutions. Over-crowding in Maryland is now less than 10%, on the basis of rated capacity.

The Commissioner keeps in touch with medical colleges and with the emergence of promising young physicians over the country. Being familiar with the aptitudes of the various physicians on the staffs of the state hospitals, he secures for the hospital superintendents the best available staff members.

Maryland takes care of its insane criminals in a special division organized in one of the hospitals. Psychotic epileptics are similarly cared for. A special division is now being planned to care for all alcoholic patients in one hospital under a form of treatment and discipline applicable to their needs.

In Massachusetts the history of the central control of all state work for those with mental disorders is intimately connected with the personality of Doctor George M. Kline, a medical graduate of the University of Michigan and for four years assistant physician at the Mount Pleasant State Hospital in Iowa, after which he spent six years as first assistant to the late Doctor Albert N. Barrett, Director of the Michigan State Psychopathic Hospital, another name honored in Iowa as belonging to one who served for years in one of its state hospitals for the insane. In 1916 Doctor Kline was appointed by the Governor of Massachusetts as Director of the newly appointed Massachusetts Commission on Mental Diseases. In 1919 this commission was reorganized and became the Department of Mental Diseases, with Doctor Kline as its Commissioner. He held this position until his death in 1933.

The Commission of Mental Diseases in Massachusetts directs all of the work for the mentally diseased of the state. The Commissioner receives a salary of $9,500 per annum with certain perquisites and an increase from year to year "not to exceed $200 a year" up to the fifth year. Under the Commissioner are three assistant commissioners, one of whom is in charge of all the work for feebleminded persons; one, of the general mental hygiene work, which is mainly preventive, and one has a staff of psychiatrists through which he provides consultations and examinations in connection with the courts of law.

Immediately under the Commissioner is an associate commissioner as his direct assistant. A suite of offices is supplied in the State House in Boston. A commission of five citizens, without salary, serve as advisors to the Commissioner of Mental Diseases. Each state hospital for the insane is under the immediate management of a board of trustees. All of these officials are appointed by the Governor.

As was noted above in regard to the state of Maryland, so in Massachusetts it was the inherent ability, the impersonal interest and the recognized integrity of the Commissioner of Mental Diseases that gradually brought about the development of the work of state hospitals and all other mental health agencies in Massachusetts into a symmetrically organized and efficiently operating unit. Doctor C. Macfie Campbell, Professor of Psychiatry of Harvard University, described him as having "the breadth of vision, imagination, practical judgment, ability to deal with men and force of character, which enabled him to put into execution the schemes which a less vigorous personality might have left as a theoretical ideal."

Aside from all prerogatives determined by law, this Commissioner and the Commission of Mental Diseases won the confidence and cooperation of the hospital superintendents and the trustees of the individual hospitals to such an extent that his abilities in the science of psychiatry and in administration became available for the advancement of the various institutions throughout the state up to the high level which they had attained at the time of Doctor Kline's death.

In New York state, also, the Department of Mental Hygiene is one of the units in the state government. Its head is the Commissioner of Mental Hygiene, who is appointed by the Governor and holds office till the end of the period of office of the Governor who appoints him. His salary is $12,000 a year.

Under the Commissioner are assistant commissioners, one of whom supervises all state work for the mentally diseased; a second, all work for mentally defective and epileptic persons; a third is in charge of the mental disorders of children and preventive work in general.

The Department of Mental Hygiene has its offices in Albany.

A medical inspector, appointed by the Commissioner of Mental Hygiene, visits all institutions, reports, examines patients and attendants, and hears complaints. The Commissioner is empowered to appoint other examiners at any time for particular purposes.

The duties of the Department of Mental Hygiene in New York are "to execute the laws of the state relative to the custody, care and treatment of the insane, mentally defective and epileptic. The Commissioner may adopt such rules and regulations governing the management of each institution, both public and private, as he may deem necessary to carry out the purposes of law." He may propose new legislation for the legislative body. He has full jurisdiction, supervision and control of the state hospitals for the insane, excepting that certain constitutional limitations are placed upon the administration of the hospitals for insane criminals. The Commissioner unifies the work of the hospitals and may arrange

for the transference of materials from one where they are not needed to another where they are needed. He receives legacies given for the improvement of the state hospitals and executes the implied trusts. He makes provision in advance for the future needs of the mentally diseased in the state of New York. He creates a bureau of special examiners and upon their reports decides when to deport alien patients found in the state. He is responsible for the appointment of superintendents of the state hospitals after their selection by the Civil Service Department. He determines the number of employes for each institution and assigns their control to the superintendents.

A former Iowa Psychiatrist, now the chief psychiatrist in one of the New York state hospitals for the insane, comments that the New York State Department of Mental Hygiene "has functioned admirably. This may be partly due to the fact that New York has had some outstanding socially-minded governors in recent times, and there is further the State Charities Aid Association that stands in a position of watch dog. It certainly keeps its eyes on whatever is happening in the state.".

The state of Michigan recently revised the state administration of hospitals and other institutions for mental diseases by making legal provision for the appointment of State Hospital Commission of seven members to be appointed by the Governor for six year terms, the terms being so arranged that only one or at most two members are changed in a given year. This Commission must meet at least ten times in a year. Its members receive travel expenses and $15 per day during the meetings. The executive offices are at Lansing.

The Commission appoints a Director, whose salary is provided by act of legislature, as an officer under their direction. He must be a physician "experienced in the treatment of the mentally afflicted."

In Pennsylvania the Department of Welfare is responsible for all state supported institutions for mental disorders, inebriacy, epilepsy and correction.

The professional work in behalf of the mentally disordered is under the immediate control of the State Mental Health Bureau, of which a psychiatrist is the Director.

Respectfully submitted,

ANDREW H. WOODS

REPORT OF THE CHAIRMAN
OF THE SUBCOMMITTEE ON HOSPITAL EQUIPMENT

APPOINTED BY THE

COMMITTEE ON HEALTH OF THE IOWA STATE PLANNING BOARD

November 23, 1938

Walter L. Bierring, M.D., Chairman
Committee on Health
Iowa State Planning Board
Des Moines, Iowa

Dear Doctor Bierring:

In compliance with your letter of April 18, permit me to present to you a report of the study and recommendations of the Subcommittee on Hospital Equipment, with reference to the four state hospitals for mental disease and the two state hospitals for mental defect and epilepsy. Herein is included a summary of the deliberations of the Committee on Health relative to the physical needs of our mental institutions, and the recommendations of this report have the approval of the Committee on Health of the Iowa State Planning Board.

Respectfully yours,

Rev. J. R. Bowen,
Chairman of the Subcommittee
on Hospital Equipment

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THE PHYSICAL NEEDS OF THE FOUR STATE HOSPITALS FOR MENTAL DISEASE AND THE TWO STATE INSTITUTIONS FOR MENTAL DEFECT AND EPILEPSY

* * *

(Report of the Chairman of the Subcommittee on Hospital Equipment appointed by the Committee on Health of the Iowa State Planning Board)

* * *

IT IS the purpose of this report to make known the immediate physical needs of the four state hospitals for mental disease and the two state institutions for mental defect and epilepsy.

The fact must be recognized that our state mental institutions are to a great extent merely custodial institutions, and even as such are very inadequate (Mental Hospital Committee Survey, p. 16). These recommendations are given for the purpose of rendering these institutions curative as well as custodial, and with this end in view, suggestions for therapeutic equipment and facilities are made with the presumption that a sufficient and capable personnel will be provided. This report is not intended as a reflection on the superintendents and those in control of our state hospitals, for in justice it must be recognized that they have been compelled to carry on without sufficient help, equipment and buildings.

These recommendations are the result of a study and survey of the state institutions involved, based on: (1) observations made by members of the Health Committee of the Iowa State Planning Board on visits to the various institutions; (2) consultation and correspondence with superintendents of mental hospitals and authorities on mental therapy in other states; (4) deliberations of the Subcommittee on Hospital Equipment and those of the Committee of Health of the Iowa State Planning Board; and (5) a study of the Survey of the State Mental Hospitals of Iowa, conducted by the Mental Hospital Survey Committee in 1937, and the Report and Recommendations Covering a Ten Year Improvement Program for the Fifteen State Institutions under the Board of Control of State Institutions, of 1938.

In these present recommendations of the Subcommittee on Hospital Equipment, the Report and Recommendations of the Board of Control will be referred to under the term "Report", and the Survey of the Mental Hospital Survey Committee under the term "Survey".

(In this report the physical needs of our state hospitals are emphasized, for this was the specific assignment given the Subcommittee on Hospital Equipment. However, it must be understood that this Subcommittee is equally cognizant of the extreme need of an increase in efficient personnel, and that it also recognized the necessity of a preventive program of mental hygiene, of out-patient clinics, and of an adequate social service to cooperate with our state institutions, especially as regards the investigation of patients and the follow-up work among cases improved and paroled.)

I. THE NEED FOR NEW BUILDINGS

The extreme evil of overcrowding, which now prevails at our state institutions, reveals the absolute necessity of new buildings.

EXTENT OF OVERCROWDING. According to the Survey, the four state hospitals for mental disease (Clarinda, Cherokee, Independence, Mt. Pleasant) are crowded to the extent of 1,665 beyond their rated capacity. According to a report of the superintendents, these hospitals are overcrowded to the extent of 1,900 patients. The state institutions for mental defect and epilepsy according to the Survey are overcrowded to the extent of 614 patients. This makes the total overcrowding of the six institutions 2,279 according to the report of the Survey, and over 2,500 according to the reports of the hospital superintendents. A summary of this condition by institutions follows:

HOSPITAL	PATIENTS	CAPACITY	EXCESS
Cherokee	1,676	1,120	556
Clarinda	1,658	1,250	408
Independence	1,771	1,245	526
Mt. Pleasant	1,495	1,060	435
TOTAL	6,660	4,675	1,925
Glenwood	1,860	1,650	210
Woodward	1,404	1,000	404
GRAND TOTAL	9.864	7,325	2,539

Building for the Four Mental Hospitals

EVILS OF OVERCROWDING. Apart from the discomfiture, and even the misery, it entails, overcrowding must be considered a distinct obstacle to the cure of the patients. It directly affects cures by preventing the proper classification of patients--and proper classification is emphasized by all doctors as an essential step in the cure of mental disease.

The overcrowding in our four state mental hospitals is so extreme that in many instances it practically precludes any personal privacy and tends to destroy in the patient all sense of personal rights and individuality. The morale of the patient is therefore destroyed and his cure impeded if not made impossible. In some instances due to lack of space the patient has not a locker for his clothes. He has only a bed in an overcrowded ward and he is compelled to put his clothes under his bed at night. These things are vitally important because they conspire to break the spirit of a man--and if his spirit is broken cure is impossible.

New patients are frequently received into wards in the main buildings--in many cases into wards with disturbed and bed-ridden patients. In some cases cots with bed-ridden patients are crowded into the corridors, a most depressing situation, to say the least. Moreover, new arrivals often become the victims of damaging gossip from disgruntled and long-term patients--and this after their having been subjected to the harsh method of commitment which now prevails in Iowa. In many isntances, therefore, the first reaction of new patients to hospital life is most unfavorable and discouraging, and frequently it is exceedingly difficult, even impossible, to efface the first impression.

It is needless to add that extreme overcrowding is unhealthful and contributes to difficulties of sanitation. It interfers with proper ventilation, breaks down the physical resistance of patients to disease, and facilitates the spread of contagion.

The Cause of Disturbance

Overcrowding indirectly impedes curative measures because it gives rise to disturbance among the patients and facilitates the danger of their injuring one another. It is well to keep in mind that in many instances serious injury suffered by a patient was inflicted not by an attendant but by an irresponsible fellow-patient.

It must be evident that these conditions make a program of mental therapy quite impossible by creating conditions which are irritating and nerve wracking to both patients and attendants, and with reference to the latter, it should be remembered that because of a shameful shortage in personnel, attendants are required to care for many patients beyond their capacity.

Lest some of the above conclusions might seem extreme, may I quote from a letter from the superintendent of one of our state hospitals? Speaking of overcrowding, he writes:

"....It greatly increases the danger of patients to each other by causing much unnecessary body contact, resulting in squabbles, fights, etc....It creates a condition of most unpleasant body odor on wards, which in winter require excessive ventilation and continuously fluctuating temperatures on the ward. (It might seem offhand that this condition could easily be prevented, but in actual practice it is far from it. This condition exists on practically all our state hospital chronic and untidy wards to some extent where large masses of these patients are packed together)...

"It makes it impossible for patients to have space for private belongings, clothing, etc....There are many patients who are perfectly capable of keeping private effects in dresser space in side rooms but the necessity of using such space for beds makes it necessary to handle all clothing and private belongings in a centralized space with each individual having a pigeonhole for his things. They are, therefore, not even accorded the private locked box that the inmates of penal institutions are privileged to have..."

Our state institutions should be enlarged as soon as possible so that the problem of overcrowding can be definitely solved, and it is the opinion of the Subcommittee that if this problem is placed before the public in the proper way, every responsible citizen will concur in this recommendation.

New Buildings Recommended

for the Four State Mental Hospitals

A WELL EQUIPPED RECEIVING UNIT FOR EACH HOSPITAL. The Subcommittee strongly recommends, as of primary importance in mental therapy, the building of well equipped receiving units. Since a receiving unit is the place where diagnosis is made, the patient observed, and his treatment outlined, and in view of the fact that the first six months of hospitalization are the most important from the standpoint of cure, it is recommended that receiving units be provided at each hospital, with special equipment, office space, etc., as will enable an adequate and highly specialized personnel, to carry on its work to the best advantage.

In order that the first impression of a newly admitted patient may be as favorable as possible, it is recommended that the receiving unit be built at some distance, and out of view, if practicable, of the hospital proper, and that interiorly and exteriorly it provide as pleasant an atmosphere as possible.

INFIRMARY OR HOSPITAL UNITS. It is recommended that adequate infirmary or hospital units be provided at each institution. In approaching the cure of many forms of mental illness, it is absolutely necessary to provide in a mental hospital the facilities for medical and surgical treatment which are to be found in a general hospital. In vain will a doctor strive to effect the cure of mental illness unless physical defects and disorders are first taken care of.

At a meeting of the superintendents of the state institutions and the Board of Control, one of our superintendents remarked:

> "...I believe when our medical work in the state hospitals is modeled after that of the general hospitals, we will get better results. The tendency has been to look to the mental side too much. When we begin to clear up the physical defects, and take care of the surgery, and make laboratory examinations, we will get better results in our mental treatment..." (Bulletin of Iowa State Institutions, Jan., 1937, Vol.XXXIX, No. 1, p. 6.)

TUBERCULOSIS UNITS. What is said of hospital units applies with equal force to more adequate and modernly equipped tuberculosis units. These buildings are necessary not only for the cure of those who are ill, but also for protection against contagion affecting other patients.

DORMITORY BUILDINGS. It is recommended that dormitory buildings be erected at each institution sufficient in number and size to alleviate the over-crowding and provide for the proper classification of patients.

AUDITORIUM BUILDINGS. The erection of an auditorium building for programs, recreational and athletic activities, as well as chapel exercises, is strongly recommended for those institutions not having the proper building or space for these necessities.

PERSONNEL QUARTERS. The Subcommittee readily agrees with the recommendations of the Survey and the Report with reference to new living quarters for doctors and other personnel. With this exception, however, that with reference to buildings for employes it appears to be in better taste and in conformity with the wishes of many employes that separate buildings for men and women be provided. It may be presumed also that this arrangement will bring better response from the public. The problem of providing living quarters for married couples can be solved as easily with this plan as with the other.

Style of Buildings

With reference to style of buildings for patients, we offer the following observations:

(1) The policy of erecting one-story dormitory buildings, as followed in Illinois, for example, reveals the following advantages:

a) Safety in case of fire;
b) Ease of administration and supervision;
c) Easy access to the open air and to the freedom of the grounds;
d) Lower cost of construction;
e) Better light and ventilation;
f) Other aspects: These dormitories and dayrooms are open to the roofs. The ceilings are insulated. There are dormer windows in the roofs which contribute to both light and ventilation. From a strictly air-space viewpoint, it is not possible to overload these buildings. (From A.L.Bowen, Director of Public Welfare for the State of Illinois.)

(2) Costs of some mental hospital buildings recently constructed. For this data, see Appendix A.

New Buildings for Mental Defects and Epileptics

The girls' custodial building and Farmers' Lodge at Glenwood are so dilapidated, according to the Survey, that it seems unwise to improve them. As a policy of economy, they should be replaced.

Buildings to provide additional space for patients and personnel, classrooms, etc., as given in the Survey and Report, are recommended--with this stipulation, however, that basement space at present not utilized in various buildings at Woodward be improved wherever possible. This space can be utilized for different departments now accommodated on upper floors and these floors can then be converted into living quarters for new patients.

In the opinion of the Subcommittee, the following considerations call for expert study in order that adequate, efficient, and economical building program be devised to accommodate the needs of the mental defectives and epileptics of the state:

(1) The question of making in a ten year program provision for the increase in the hospitalization ratio of the feeble-minded and epileptics;

(2) The question of a separate hospital for epilepties;

(3) The question of providing for such mental defectives as are to be found at the state institutions at Mitchellville and Eldora. (Survey, p.41)

II. ELIMINATING FIRE HAZARDS

A letter was sent to the office of the state fire marshal asking if there had been an official inspection of the state hospitals and if any of the buildings had been condemned. The reply of the state fire marshal reads in part:

> "This office has made an inspection of the state institution at Mt. Pleasant. This was a full day inspection and we were just able to inspect the buildings occupied by patients.
>
> "The Mount Pleasant institution is the oldest of the four similar institutions and we found a great number of hazards. These hazards and suggestions for their removal were contained in a report to the Board of Control.
>
> "Perhaps the worst hazard was that connected with the electric wiring in the institution, also the inaccessibility of emergency exits for the patients in case of fire.
>
> "So far as we know, this building has never been condemned, nor have any of the other institutional buildings.
>
> "We believe that on account of insufficient appropriation, the Board of Control is handicapped in taking care of these suggestions."

Nevertheless, it is plainly evident that some of our state hospital buildings in their present condition should be condemned as fire hazards or that their immediate improvement be ordered by competent authority. Fire risks in poor wiring, lack and inaccessibility of exits, which the fire marshal's report indicates as existing at Mt. Pleasant, are to be found in many other buildings of the State Hospitals.

To give an example of a typical fire hazard, one might mention conditions which prevail in different parts of the main building at Mt. Pleasant. For instance, at either end of the building one exit must serve four floors with an overcrowded ward emptying into it from either side on each floor. This means that if a fire were to cut off this double tier of wards, eight wards from four floors, the patients would have to crowd into a narrow stairway. This stairway is a frame structure and the stairs are only four feet wide. The steps are narrower than the ordinary step, and are worn and slippery from much use. In the event of fire, one can easily imagine the congestion, especially when the patients from the lower floors would meet the patients descending from the floors above. The building in question is almost eighty years old and houses a thousand patients. The interior structure, floors, casings, etc., are frame and through the years the floors and woodwork have been soaked with oil and wax and constitute a dangerous fire risk.

Exits of the kind described above, serving a number of wards on three or four floors, are not limited to Mt. Pleasant, but are to be found also in other state hospital buildings. And if a fire were to break out at night the danger to these institutions would be much greater because of the few attendants who take care of the various floors during these hours. Complaining of this danger, a superintendent of one of these institutions said a little over a year ago in an address to the superintendents of the state hospitals and the Board of Control:

> "..At night we have 15 wards with no night attendants. Most anything can happen on those wards. Perhaps, however, the greatest danger is from fire, as these patients are locked up with no employee to unlock the door or protect them if fire breaks out. I should like to recommend that fire doors be installed to prevent the spread of fire from the wards of the main building." (Bulletin of Iowa State Institutions, Jan., 1937, Vol.XXXIX, No. 1, p.16)

We must remark that because of insufficient appropriations, nothing could be done about this matter.

According to the Survey, p. 43, the girls' custodial building at Glenwood should be abandoned. This building houses more than 400 children the great majority of whom are of low grade mentally, and for the most part entirely helpless. This structure constitutes a distinct fire risk, and the means of exit are poor. In case of fire, a goodly portion of the population would be destroyed. Moreover, the physical condition of the building presents a serious menace to the lives of the children. It is in danger of collapse, for its west wall is bulging to the extent that the upper floors are pulled apart in some places more than an inch.

There is an average of more than one fire every day in the ten thousand hospitals (medical, surgical, and mental) in the United States. This fact should awaken us to the evil of fire hazards as they now prevail in our mental institutions. Indeed, these hazards present such a menace to the lives of so many patients in our state institutions that in the opinion of the Subcommittee an official investigation of all hospitals, resulting in an official mandate for the removal of such hazards, should be undertaken at once.

RECOMMENDATIONS AGAINST FIRE CASUALTIES

a) More accessible fire exits;
b) Steel conduits for electric wiring;
c) Fire doors to be placed at strategic points throughout the buildings;
d) The placing of helpless patients on lower floors whenever possible;
e) The use of a sprinkler system wherever advisable;
f) Adequate fire-fighting apparatus, which should be inspected frequently, kept in good repair, replenished when necessary, and conveniently placed.

III. THE NEED OF PORCHES

The lack of porches on many of the buildings of the state hospitals is to be deplored, and we recommend the erection of porches wherever possible, for the wards of all buildings which have none.(Survey, p.28).

Where fire escapes are needed, porches with fire escapes could be economically and practicably attached to the buildings. The idea of porches with fire escapes is not new to hospitals, and such porches can be ornamental as well as serviceable without being of the same material as the building. Besides offering the advantages of fire escapes, the porches offer much in the way of recreational space and facilities to the patients especially at times when they must remain indoors.

We must realize that the rehabilitation of our state hospitals may take a long time. Buildings of any worth now standing will continue to stand for many years. In recommending porches for these buildings we have only in mind the comfort and diversion - as well as the safety, where fire escapes are needed - of the patients who will be confined to such buildings during these years.

IV. PROTECTION OF MILK AND WATER SUPPLY

The Subcommittee urgently recommends that immediate steps be taken to protect the water supply, also the milk supply where needed and recommended by the superintendents of the hospitals.

V. LAVATORY FACILITIES

The inadequacy of lavatory, toilet, and bath facilities in practically all of the buildings of the state hospitals cannot be stressed too strongly, and their enlargement must be emphasized in considering any improvement program. The construction of filtration plants wherever needed is also advised.

VI. REPLACEMENT OF FLOORS, WINDOWS, ETC.

As mentioned before, the floors and woodwork of the older buildings of our state hospitals have long been soaked with oil and wax and they not only constitute dangerous fire risks, but also offer a refuge and breeding ground for vermin of all kinds, and this notwithstanding the use of all modern means of extermination. This makes sanitation difficult and constitutes a serious menace to the comfort of the patients. It is therefore recommended that a program of floor and woodwork replacement be inaugurated at once, and in such a way that a number of floors orwards will be remodeled each year until the interior construction of all worthwhile buildings is made fireproof and sanitary.

We further recommend that this program will include the replacement of barred windows with modern hospital windows. A program of this kind has been started at Cherokee, where one ward has been completely overhauled and refinished.

VII. DINING ROOM SERVICE

In too many instances meals are served to patients in dining rooms on the wards on which these patients are confined. For the most part these dining rooms are very unattractive. And where they are located at any distance from the kitchens it is most difficult to keep the food warm until it reaches the patients. A central dining room for the institution, or central dining rooms accommodating the patients of different buildings or sections of buildings offer many advantages.

The modern hospital has advanced far in the service of foods, through the central dining room idea, the cafeteria, the conveyances for bringing hot foods to the wards. This modern program of food service not only results in greater benefits to the patients but also in greater economy to the institution.

Therefore, the Subcommittee recommends that special study be given to provide the best possible kitchen and dining room service according to the types of patients to be served and the building plan of the different hospitals.

Central dining rooms with cafeteria service are highly recommended because of the following advantages:

a) The simplified serving of hot foods;
b) The advantages in the selection of foods by patients;
c) Economy to the institution in the great saving on waste of food;
d) The desirable therapeutic effect on the patients themselves, produced by the social advantages this service offers and the opportunity given the patients of serving themselves.

VIII. THERAPEUTIC EQUIPMENT

It is plainly evident that the therapeutic equipment in our hospitals is inadequate, and in many cases sadly so. Provision should be made to bring our hospitals up to modern standards in this respect. Equipment for hydrotherapy is to be found, it is true, but it is not adequate to bring the facilities of this important treatment to all the patients who can be benefited by it.

Modern occupational therapy units are wanting. This form of therapy is considered a very important means for the rehabilitation of the mentally ill. With "continued unrest the cells of the brain itself may show evidences of deterioration." Occupational therapy has proved its worth by bringing about a state of mental rest, by reawakening an interest in things, and by reestablishing a feeling of confidence and security. Frequently through this therapy a patient finds contentment in his surroundings for the first time. The further advantage of this therapy lies in the fact that it offers the psychiatrist a splendid means, and in some cases the only means, of observing the mental reactions of his patients. The Subcommittee, therefore, urgently recommends the establishing as soon as possible of adequate occupational therapy units in all our institutions for mental disease and mental defect.

With reference to the design of an occupational therapy unit, the Subcommittee recommends that a sound-proof room be included for work on metal, and that a special room be included for irresponsible patients. An occupational unit of this type is now being built at the Neuropsychiatric Institute of the University of Michigan.

IX. RECREATIONAL FACILITIES

We recommend that more ample facilities be provided for organized and supervised recreational activities in all our hospitals, according to the recommendations of the Mental Hospital Survey Committee as given in the Survey on page 19 under the captions, Physical Education, Music, and Bibliotherapy. Following the recommendations of the Survey, provision should be made for additional recreational facilities for the summer months at Glenwood.

However, what follows refers to activities through which the patients may amuse themselves while indoors. Besides cards, we suggest diversion in the way of pool, billiards, table-tennis, checkers, etc., for men, and similar diversions for women, to be encouraged and supervised by attendants. With reference to indoor amusements we make the following recommendations.

New buildings should include sufficient recreational space (day space) and facilities. In old buildings wherever possible provision should be made for such space and facilities for all wards housing patients who can be benefited by them.

Importance of Such Facilities

Such facilities are necessary not only for the diversion of patients but also as part of the curative process. One might visit some of the wards of our state hospitals in the daytime when many of the patients are out-of-doors and not be impressed with the need of recreational facilities in the

wards. To visit the wards in the eveing, however, or during inclement weather, is to receive an entirely different impression. One is then struck not only with the magnitude of the overcrowding but also with the deadly monotony of hospital life as it now prevails in our mental institutions. The means of recreational distraction are negligible, and the mind of the patient must become dormant for lack of diversional stimuli, or revert to brooding and worry. A large percentage of mental patients are conscious of their plight. Consequently authorities on mental therapy are convinced that anything in the way of amusement has a great influence on the cure as well as the entertainment of such patients.

The use of radios should be encouraged as much as possible. A number of wards in our state hospitals have radios, and we are informed that they were installed by the patients or personnel of the institution, or furnished from the profits of the hospital canteens. In other states a number of mental hospitals operate their own radio stations, and the patients contribute to the program building, announcings, and minor repairs on the radio system. The director of the radio department of Worchester State Hospital (Massachusetts), in the annual report for 1937, declares: "After seven years of experimentation and careful study we have found that the radio system does definitely contribute to the happiness and health of patients."

Other Improvements Recommended by the Report

The Subcommittee also concurs with the superintendents on the necessity of other improvements outlined in the Report. As to the estimated cost, however, of some of these improvements, as given in the Report, the Subcommittee does not deem it expedient to commit itself until it has further knowledge of the conditions under which these improvements must be made, and which might easily influence the cost.

X. THE QUESTION OF BUILDING A NEW GENERAL MENTAL STATE HOSPITAL

Practical Size of Mental Hospitals

From correspondence with mental hospital authorities, the following conclusions were reached. A mental hospital with a patient capacity of not more than 1,500 is to be preferred. While this figure is arbitrary, it should be approximated as closely as possible. It is a mistake to let hospitals exceed a capacity of 2,000. In answer to a query on this matter, the National Survey Committee for Mental Hygiene replied that all possible influence should be used to keep the capacity of the mental hospitals of Iowa in the neighborhood of 1,500 beds. Another authority gave the following answer to the query:

> "There is no exact figure at which one has to increase personnel and at which the superintendent begins to lose track of individual patients, but it is somewhere around this figure"(1,500 beds).

In approaching the evil of overcrowding which now prevails in our state hospital, and in making provisions for the anticipated increase in the hospi-

tal population for the next ten years, we offer the following as a practical solution to the problem:

(1) To relieve our mental hospitals now operating of overcrowding by providing additional space for the patients confined in them, and to bring these hospitals and buildings up to modern standards of personnel and physical set-up; and,

(2) To make immediate provision for a new general mental hospital (1,250 or 1,500 beds), as recommended by the Survey.

The Need of a New General Mental Hospital

Using the figures of the Survey for 1937, Clarinda has an excess of 408 patients. The new building recommendations of the Board of Control would accommodate 550 patients, which would provide for only 142 more patients than were in the hospital last year. This number would easily be absorbed in a short time. It certainly would not survive a ten-year building program. The same is true of the other hospitals. The figures for the four run as follows:

HOSPITAL	PRESENT EXCESS	CONTEMPLATED ACCOMMODATIONS	EXTRA CAPACITY OF NEW ACCOMMODS.
Clarinda	408	550	142
Cherokee	556	700	144
Independence	526	708	182
Mt. Pleasant	435	300	-135

Estimated Population by 1947

Extent of overcrowding in 1937	1,900
Anticipated increase in population of mental hospitals by 1947	1,600
Total number of patients to be provided for over present capacity of 4 mental hospitals by 1947	3,500

In 1927 there were 5,300 patients in our four mental hospitals. In 1937 there were 6,600 patients in the same institutions. This represents an increase of 1,300 patients or an average of 2.45% per year. Using this ratio for the next ten year period, 1937 to 1947, gives us an increase of 1,600. According to a questionnaire which was sent to various mental hospital authorities throughout the country, this is a conservative estimate, and it closely approximates the increase in mental hospital population according to the hospitalization ratio of Table V page 65, of the Survey.

According to this data the State of Iowa in eight years should provide bed space for 3,500 patients beyond the present bed space of its mental hospitals. The Ten Year Program of the Board of Control, which at best cannot get under way before the middle of 1939 or the Spring of 1940, does not make provision for more than 2,300 beds of the 3,500 which will be needed by 1947. This leaves a deficit of 1,200 beds, and offers substantial argument for an additional mental hospital.

A Conservative Estimate

We said that an increase of 1,600 in our hospital population by 1947 is a conservative estimate. In appendix C we outline factors which tend to increase and those which tend to decrease the population of mental hospitals. However, here we deem it important to mention two factors which can reasonably be expected to raise the increase in the population of our mental hospitals above the 1,600 figure.

(1) As hospitals are improved the public gains more confidence in them, and consequently they will send more relatives to them. At present there are close to 600 known cases of mental illness being cared for in the homes of Iowa.

(2) Advances in health work of all kinds have increased the average lifespan, so that more people are continuing to enter the old age group, in which a special type of mental disorder, senile dementia, occurs; this variety of mental illness is seldom improved in an institution, however fine, for it involves changes in the physical organs due to old age. "This", says, a letter from the New York Committee for Mental Hygine, "must be considered as extremely important, because all statistical studies bearing on the subject point to a heavy increase in the older section of the hospital population in the future." This is also borne out in an extensive study made a few years ago by the National Committee for Mental Hygiene.

The above considerations clearly indicate that unless immediate provision is made for the building of an additional general mental hospital, the evil of overcrowding will not only remain with us while the Ten Year Program of the Board of Control is being carried out, but further indicates that after that program is completed, our state hospitals will be as overcrowded as they are today. And this would precisely parallel the sad history of mental hospitals in the United States; for in studying the history of mental institutions in this country, one is struck by the fact that the mistake seemed ever present of adopting building programs without making allowance for the increase in hospital population; and as a consequence, the problem of over-crowding - even after the completion of building programs has always been with us.

Therefore, as a necessary factor in the cure and comfort of our mentally ill, and as an expedient of economy, the Subcommittee on Hospital Equipment re-asserts the following recommendations:

(1) Not only to relieve our mental hospitals now operating of overcrowding by completing the building and improvement program outlined in this report;

(2) But also to make immediate provision for a new general mental hospital (1,250 or 1,500 beds) as recommended by the Survey.

NOTE: By "immediate provision for a new general mental hospital" is meant that preliminary steps involving location, plan, and cost of building, be undertaken at once, so that building operations may be definitely considered for the biennial period beginning in 1941. (For cost of mental hospitals recently erected, see Appendix B.)

XII. THE CALL FOR HELP

In conclusion we quote from the Biennial Report of an Eastern mental hospital superintendent who is an authority in his field. This superintendent terminates his report with the words:

> "...This is not a matter of humanitarianism only, but a matter of dollars and cents of public funds, of which the representatives of the people are so cognizant. Surely one does not have to be a physician or psychiatrist, trained in the field of mental and nervous diseases to recognize the obvious fact that before one can attempt to assist a mentally handicapped individual, one must at least offer a decent, fairly well ventilated, and comfortable space to exist...
>
> "... Because of the above mentioned facts, through no fault of the Board or the executive officer of the hospital, the percentage of recovery has been handicapped seriously. It is obvious that through this so-called "false economy" we have added to the large number of the incurable hopelessly ill group, an additional number, the care of which will be the concern of all thinking men and women of the state." (Tarumianz, M.A., M.D., Superintendent, Delaware State Hospital, Biennial Report, Wilmington, 1937.)

In this spirit, then, this report is respectfully submitted.

Rev. J. R. Bowen, Chairman
Subcommittee on Hospital Equipment
Committee on Health
Iowa State Planning Board

APPENDIX A.

COST OF ADDITIONAL BUILDINGS TO MENTAL HOSPITALS OF OTHER STATES.

The cost of new buildings varies according to material and labor rates, etc. However, the following figures from recently constructed mental hospital buildings might prove helpful. Equipment is not included unless specified.

1) Receiving units. Missouri: 120-150 bed capacity - $2,329-$2,736 per bed.

2) Infirmary units: Missouri: 320-553 bed capacity - $1,000 per bed. (Both figures from L. Roy Bowen, supervising architect of eleemosynary institutions for the Bi-Partisan Planning Board of the State of Missouri)

3) Ward Buildings. Illinois: Single story - $1,300 per bed, including furniture, fixtures, and furnishings. (Figure from A. L. Bowen, Director of Public Welfare, State of Illinois.)

Minnesota: Approximately $1,000 per bed with equipment. (Figure from C. R. Carlgren, Chairman of the Department of Public Institutions, Board of Control of the State of Minnesota.

Colorado: $650-750 per bed. These buildings are fireproof, except for the floors, etc., and the doors to the various rooms and dormitories, which are also of wood. The floor plans consist of a large day hall, single rooms in 20% of the space, and the remaining 80% dormitory space. (From Dr. F. H. Zimmerman, superintendent of the Colorado State Hospital, Pueblo.)

New Hampshire: $1,500-$2,000 per bed. Equipment not specified. (From Dr. C. H. Dolloff, Superintendent of the New Hampshire State Hospital, Concord.)

The above figures represent the lowest costs obtained.

APPENDIX B.

COST OF A COMPLETE NEW HOSPITAL INSTITUTION

Cost of a new completely equipped hospital in Minnesota has been approximately $1,800 per bed, in that state's $5,000,000 institution program. And during recent years the cost of custodial buildings has been approximately $1,000 per bed - higher than it would have been in 1930, 1931 or 1932, when lower building costs prevailed. (Figures from C. R. Carlgren, Chairman of the Department of Public Institutions, Board of Control of the State of Minnesota.

The Mental Hospital Survey Committee gives the average range of costs in the United States as from $2,000 to $4,000 per bed, depending on section of the country, cost of labor, materials, etc.

A letter from the New York City Committee on Mental Hygiene states that the cost of a new general mental hospital in New York has been roughly estimated at $3,000 per bed.

The cost of the new State mental hospital at Ypsilanti, Michigan is given as $1,200 per bed. (Note. This hospital is significant from the standpoint of size. At first it was intended to build a 3000 bed institution. This size, however, was later abandoned as not practical and a 1500 bed hospital was decided upon. Figures furnished by Albert Kahn, architect, Detroit.)

APPENDIX C.

FACTORS AFFECTING POPULATION IN STATE HOSPITALS

(1) FACTORS TENDING TO INCREASE POPULATION:

a) Improving service, which gives the public more confidence, so that they are more willing to send relatives to state hospitals.

b) Public education in mental hygiene, through which more people will be willing and eager to seek scientific treatment: the "stigma" attaching to mental hospitals for treatment.

c) Public Health work, which discovers mental cases and directs them to mental hospitals for treatment.

d) Increasing of average lifespan, with the result that more people are entering the old age group, and increasing hospital population in the senile dementia category.

(2) FACTORS TENDING TO REDUCE INSTITUTION POPULATION

a) Active campaign against veneral diseases, which diseases often comprise up to and over 10% of hospital populations.

b) Corresponding campaign against other organic causes of mental disorder, which aspect of health education work operates towards the reduction of hospital population, with the exception of the senile dementia group.

c) Utilizing the old age pension and social security program in retiring of older patients who could be favorably cared for by their families if it were not for economic conditions.

d) Improved Mental Hospital Facilities, and

e) New Methods of treatment:

I. Family care, in which quiet patients are boarded in private families in the vicinity of the institution;

II. Adequate parole service, with careful investigation and supervision;

III. Development of the field of psychiatry, such as in the administration of insulin, metrazol, and camphor for dementia praecox; child guidance clinics, clinical treatment of patients with early symptoms, visiting teachers in the public schools, child guidance clinics attached to children's courts; educational work with parents, teachers, nurses, looking toward normal personality development of children.

(3) FACTORS THAT ARE CHANGEABLE OR VARIABLE.

a) Changes in general population of a state.

b) General economic condition of the public: In bad times relatives tend to seek commitments of mental patients in order to avoid the expense of maintaining them at home. In good times it is easier for mental patients to find employment, and so in good times relatives are less inclined to commit, and institutions feel more free to parole.

APPENDIX D

IOWA'S CURVE IN GENERAL POPULATION

Year	Population	Increase	%Increase
1910	2,224,771		
1920	2,404,000	179,229	8 %
1930	2,470,939	66,939	2.7 %
1940	2,581,029(estimated)	110.090*	4.45 %

* Computed from the increase for the years 1930-1937 as estimated by different authorities.